

INFORMED CONSENT TO MASSAGE THERAPY AND CARE

I \_\_\_\_\_ of my own free will, consent to be treated for the  
(Patient's Name)  
following condition: \_\_\_\_\_  
(description of condition/chief complaint)

I acknowledge that my therapist will provide me with such information as is pertinent to the treatment for the above listed complaint. Alternative methods of treatment (where applicable and relevant) have been explained to me, as well as the possible risks and side effects, if any. I feel that I fully understand what is involved in the proposed treatment and what the possible consequences of not having treatment may be.

I understand that I may change my mind regarding any aspect of this treatment, at any time and upon informing my therapist of my decision, I may withdraw consent with the intent to alter or discontinue the treatment.

I acknowledge that for the purpose of integrated therapy the following areas may be addressed during the course of treatment: chest, arms, back, abdomen, buttocks, legs, hands and feet (breast and groin areas are excluded).

I do not wish the following areas to be treated: \_\_\_\_\_  
(initial or list areas to indicate no preference)

In compliance with the "consent to treatment Act", Bill 109, I provide my full voluntary consent to treatment.

I acknowledge that I am completely responsible for payment of treatment(s). If for any reason my insurance company does not approve payment I will assume the outstanding balance.

**Respectful Workplace**

We request that you use respectful language and behaviors, shouting, name calling, swearing, sexually suggestive comments, inappropriate touching, alcohol or illegal drug use will not be tolerated during your visit.

Our goal is to provide services in a respectful way and in a safe and healthy environment. We ask for your help in achieving this goal.

**TO BE COMPLETED BY PATIENT:**

\_\_\_\_\_  
Print Patient Name

\_\_\_\_\_  
Signature of Patient  
(or Parent/Guardian)